Welcome to

(Please fill out both sides.)

Confidential Patient Information

Patient Name: ____ Date:_______________
Last First MI DAY / MONTH / YEAR

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____________

Birth Date: (DAY / MONTH / YEAR)_________________________
Name of Spouse____________________________________ Names of Children________________________

Phone (Home): ________________ ___(Work): ________________ Ext:______ Best time to call:_____________
Mobile_________________________Email___________________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ____
Street Apartment #

____
City Province Postal Code

Health Information

Name of Previous Dentist:____________Date of Last Dental Visit: _____________Reason for this visit: ________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergies __________ __________________
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths

☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker

☐ **Pregnancy**
Due date:__________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy

☐ Penicillin Allergy
☐Latex Allergy

Please list your Medications:

____
____
____
____
____
____
____

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes, please explain: ____________________
- Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes, please explain: ________
- Are you now under the care of a physician? ☐ No ☐ Yes, please explain:______________________________
- Name of Physician: ____ Phone: ___________________________
- Do you have any health problems that need further clarification? : ____

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, ___________________________________
☐ Shopping in Plaza ☐ Yellow Pages ☐ CanPages Directory ☐ Newsletter
☐ Road Sign ☐ Newspaper ☐ Television Commercial ☐ Other: ________